Gender Dynamics in Women's Abilities to Use Microbicides

Learning from Women and Men in HIV-Impacted Communities in South Africa, Kenya, and Zambia

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Acronyms

ARV	Antiretroviral
CAPRISA	Centre for the AIDS Programme of Research in South Africa
GCM	Global Campaign for Microbicides
KEMRI	Kenya Medical Research Institute
KNBS	Kenya National Bureau of Statistics
NGO	Nongovernmental Organization
NIH	National Institutes of Health
PRA	Participatory Rural Appraisal
STI	Sexually Transmitted Infection
SWEAT	Sex Workers Education and Advocacy Taskforce
TFV	Tenofovir
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
ZDHS	Zambia Demographic and Health Survey

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Founded in 1998 and housed at PATH since 2001, the Global Campaign for Microbicides (GCM) was a civil society initiative committed to the ethical and accelerated development of, and access to, new HIV biomedical prevention tools for women. Without vested interest in any particular product or prevention strategy, GCM served as an independent, trusted advocate for women, particularly those most vulnerable to HIV. GCM engaged women from communities with increased HIV incidence to learn the end-user perspective on using HIV prevention tools. In order to gain the trust and support of local communities, in 2009 GCM began to build a staff of predominantly African women advised by a steering committee of predominantly African individuals who are actively engaged in microbicide development. This helped support and guide GCM's mission and development, in addition to increasing access to women at greatest risk of HIV/AIDS in African communities.

Introduction

The 2010 estimate of the global HIV/AIDS epidemic is 34 million people worldwide. Of these 34 million, 68 percent reside in sub-Saharan Africa, a region housing 12 percent of the total world population.[1] Globally, women represent more than half of the epidemic, which is in part a result of their bio-psycho-social environment; biologically, women's bodies are at greater risk of susceptibility due to the pathways of transmission.[2] Around the world, women frequently lack access to HIV prevention programming. Moreover, the recommendations that women do receive can be difficult to implement due to the discrimination and violence that some women experience. Women's choices regarding the use of HIV prevention tools may depend on their relationship status or other circumstances.[3] There are numerous contributing factors to explain why women are disproportionately impacted by the HIV epidemic globally, and specifically in sub-Saharan Africa where GCM conducted its work. Women may be at a disadvantage in protecting their bodies because of economic, legal, religious, and other factors that contribute to women's poverty and/or encourage risky behaviors.[2] For example, in some communities men are encouraged to have multiple partners, while women are encouraged to remain faithful to their partners. Economic or legal issues may also contribute to strong gender disparities because, in many communities around the world, women are unable to own property or have access to financial resources, rendering them dependent on men—either fathers, husbands, brothers, or sons—in order to support themselves.[3,4] It should be noted that within each country and community, women experience different and unique circumstances that may place them at greater risk of HIV, and not all women are at a disadvantage due to violence, legal, or economic factors. It is important to recognize that some women consent to or negotiate with the factors that can place them at risk of HIV.

Throughout the 1900s, women's movements across the globe gained significant momentum to empower women to fight for their freedom, health, and rights and more recently emphasized programs to support women's protection from HIV/AIDS. During the 1990s, the United Nations began a campaign entitled "Gendering the Agenda" to significantly propel the movement of empowering women worldwide by engaging local, national, and international organizations to come together and share their successes and partner to reach further into communities and governments.[5] It was during this time that GCM was born as an advocacy group fighting to ensure that women had access to HIV prevention options and to ensure that science continued to develop HIV prevention options for women. GCM partnered throughout its lifespan with numerous organizations to support women and their access to HIV prevention options. The campaign eventually transitioned its focus from global in scope to a specific emphasis on

working with and for African women, particularly in three countries that are uniquely involved in developing HIV prevention options for women.

One of these HIV prevention options for women is an effective microbicide, especially when used in conjunction with condoms. Some stakeholders posit that microbicides represent a critical component in the fight against HIV because, even though programs directed toward behavior change, condom use, and treatment of sexually transmitted infections (STIs) are crucial, there are numerous environments, contexts, and situations where condom use is not feasible or desirable; therefore, microbicides will provide a chemical barrier rather than a physical barrier between sexual partners.[6]

The first proof-of-concept for a topical gel – tenofovir (TFV) – was announced during the AIDS 2010 conference in Vienna, Austria by the Centre for the AIDS Programme of Research in South Africa (CAPRISA) 004 research team lead by Professor Salim Abdool Karim.[7,8,9] This announcement emphasized the need to expand the focus of the microbicide field from research and development to preparing for first implementation of TFV gel in Africa. During GCM's transition in 2010 to focusing on the Africa region, GCM evolved its programming to join advocacy at the government level for women and microbicides with efforts to improve access for women at increased HIV risk at the community level.

In 2011 and 2012, GCM conducted specific activities to promote HIV prevention options for women in three African countries: South Africa, Kenya, and Zambia. Given the critical need for GCM's work across all of sub-Saharan Africa, GCM selected these three countries for specific reasons. First, South Africa is striving to become the first country to introduce a microbicide; it is hosting several microbicide trials across the country and is working at the research, community, and government levels to develop a preparedness and introduction program. Similarly, Kenya is working to become the first East African country to introduce a microbicide and was the first country to include both women and microbicides in its 2012 National HIV/AIDS Strategic Plan (NSP).[10] Finally, Zambia greatly contrasts with both South Africa and Kenya in its support of microbicide efforts. Zambia initially hosted a microbicide trial in Mazabuka, but due to an incident involving misinformation shared with the media, the Zambian parliament banned all microbicide trials in 2009.[11] GCM elected to begin advocating in Zambia to bring the trials back through appropriate education in the community, the media, and the government. In 2012, microbicide trials are again launching in Zambia.

> *"If we had a microbicide today, I would definitely use it."*
> *~Female participant, Kisumu, Kenya*

This report's objective is to highlight the gender practices and norms that exist in the communities in which GCM worked that may impact the introduction of a microbicide, and to encourage the development of future successful microbicide introduction programs that address gender dynamics and empower women to use HIV prevention tools. GCM believed that the best method of introducing new technologies is to learn the opinions and experiences directly from potential end-users regarding what would encourage or limit their ability or desire to utilize these new products, as well as their perspectives on gender dynamics in regard to protecting themselves from HIV. This report reflects GCM's efforts to gather this information through its advocacy and community mobilization activities.

Epidemic and Contributing Factors to Gender Dynamics

South Africa. In 2010, 70 percent of new HIV infections worldwide occurred in sub-Saharan Africa. In this region, South Africa is estimated to have the most people living with HIV/AIDS.[1] According to the South African Department of Health, the national HIV/AIDS prevalence is 17.9 percent (approximately 5.6 million people). More than half (52 percent) of the total South African HIV-positive population are women. Interestingly, women from ages 30 to 34 remain at the greatest risk, consisting of 42.6 percent of the HIV/AIDS population in South Africa.[12] These women are at a disadvantage in protecting themselves for a number of reasons, including the potential for intimate partner violence, limited access to education and resources, and limited ability to advocate for safe sex. One landmark study in South Africa demonstrated that one in seven HIV cases among young women could have been prevented if the women were not subjected to intimate partner violence.[13] According to the 2003 South African Gender-Based Violence and Health Initiative, 2 out of 100 South African women are raped each year.[13] There are programs, including the Men as Partners program run by Engender Health, that engage male community members to reduce violence against women and to promote constructive roles for men in women's sexual and reproductive health.[14] Another effort, the women's empowerment and social mobilization program launched by Project Concern International in 2008, develops communication campaigns and engages the government to develop and support laws that protect women from violence. This program reaches across South Africa to empower women and men to have healthy relationships and to reduce women's risk of HIV/AIDS.[15] This is just one example of the numerous programs reaching across South Africa to empower women and encourage women's safe and healthy sexual and reproductive health.

Kenya. According to the 2011 Kenyan AIDS Update, 1.6 million Kenyans (4 percent) are living with HIV/AIDS, with the adult population (ages 15 to 49 years) representing 6.2 percent of the total Kenyan epidemic. Furthermore, women are disproportionately affected by the HIV epidemic (59 percent prevalence).[16] The Kenyan National Bureau of Statistics (KNBS) has cited studies demonstrating that women living in urban settings are at a greater risk of contracting HIV than those in rural settings. Studies outlined in this report also demonstrate that women are less likely to have formal employment and that 26 percent of women are not paid for their work, which may leave them reliant on others for economic survival. The KNBS also detailed recent evaluations which reported that 39 percent of Kenyan women over the age of 15 reported that they have experienced gender-based violence at some point in their lives; approximately 45 percent of adult Kenyan women have experienced either physical or sexual violence at some point in their lifetime. Moreover, partner-based violence gradually declines as marital wealth increases or as male partners have increased levels of education.[17] There are a number of programs available in Kenya, such as programs coordinated by the United States Agency for International Development (USAID), to support reducing gender-based violence. These include programs to work with men and boys to change their attitudes about violence against women (International Rescue Committee) and support legislation for women's rights, as well as programs that work with faith-based organizations and religious leaders to reach women across the country by using media, local organizations, and other methods.[18]

Zambia. The results of the 2008 Zambia Demographic and Health Survey (ZDHS) indicated that 14.3 percent of adults (15 to 49 years old) are HIV positive. Young women ages 15 to 19 are five times more likely to be infected compared with men in the same age group. Gender norms,

gender-based violence, high rates of alcohol abuse, and poverty coupled with sexual practices such as dry sex can further threaten women's health. The vulnerability of women to HIV infection is directly and indirectly impacted by multiple concurrent partnerships conducted by men and women (predominantly men), low and inconsistent condom use, low levels of medical male circumcision, high mobility, and labor migration.[19] Furthermore, studies demonstrate that approximately 47 percent of Zambian women over the age of 15 have experienced physical violence, while 20 percent of Zambian women have experienced sexual violence.[20] In an attempt to reduce the prevalence of violence against women and provide support, the US government worked with the Zambian Sexual and Gender Based Violence Coordinated Response Center to institute and support programs such as media campaigns, community programs, educational programs, and medical services to support victims.[21]

Given the depth of the HIV/AIDS epidemic in these countries, in addition to the gender dynamics and other factors that can place women at an increased risk for transmission, introducing microbicides will require a cohesive plan with a multi-faceted approach. It would be impossible to develop one model that can be implemented across sub-Saharan Africa or even across one country. The contributing factors that perpetuate the unbalanced gender dynamics and expose women to risk require a comprehensive model that incorporates women's current strategies to address the gender imbalances in their lives, in addition to being a model that is consistently monitored during roll-out and evaluated for effectiveness.

Methodology

Throughout fiscal year 2011-2012, GCM piloted specific activities to identify appropriate methods of engaging targeted high-risk communities in South Africa, Kenya, and Zambia. These efforts were conducted to develop a greater understanding of community members' opinions regarding specific gender norms in their communities, in addition to highlighting potential opportunities to introduce HIV prevention biomedical technologies to women at greatest risk for HIV infection. Furthermore, GCM found these activities to be highly effective methods of engaging with potential end-users and learning their specific insights regarding microbicide use, points of entry, access, and gender balances. The goal of these exercises was to understand from a community perspective, and particularly from the perspective of women, opinions about the best practices and methodologies of introducing new HIV-prevention technologies. It is important to note that the goal of these activities was not to develop generalizations about the communities, women, or countries, but to learn and understand opinions and perspectives from specific community members about HIV and microbicide use in their communities.

GCM's operating strategy is that programs are provided by Africans for Africans; this practice ensures that GCM has the language and cultural context to meet the needs of the people. The foundation of this program is derived from the Participatory Rural Appraisal (PRA) methodology, which encourages local individuals to discuss and analyze their understanding of life and conditions for the purposes of planning and acting to their benefit.[22] GCM's methodology adopts the main goal of PRA to encourage open discussions with community groups in an attempt to develop solutions that communities will be more likely to use. In general, GCM facilitated group discussions with an average of 20 participants who were usually identified by a community nongovernmental organization (NGO) with which the campaign partnered. GCM staff members would begin by identifying the type of dialogue they wished to host and a basic description of the participants (e.g., sex workers, young women, couples,

community elders, health care professionals, etc.). Next, GCM staff would identify a specific local NGO (Sonke, Desmond Tutu Research Foundation, Partners in Prevention, Government of Kenya–Ministry of Youth Affairs Likoni Constituency, Liverpool VCT Care and Treatment, Bar Hostess Kambi Moto Community Group, and others) that had connections within the community to help gather participants in a designated venue. Once the participants had arrived and signed in, GCM staff would introduce themselves and the topics for discussion for that day. Some events began with the women singing and dancing to help break the ice. GCM staff members would start the discussion by describing a story about their personal risk to HIV infection to encourage an open environment for participants to share their stories and experiences. Staff would expand the discussion by asking questions about perceptions of HIV risk and preferred microbicide points of access and cost, and allow for final comments. At the conclusion of each event, GCM would provide the participants with a transport stipend of approximately US$4, lunch or a food box, and, when available, a GCM t-shirt. All participants were made aware of the purposes of the activities and how GCM intended to share their opinions. Participants also were provided with options to excuse themselves from the discussion or abstain, and were given contact details of the GCM staff in case they had any follow-up questions or comments.

In order to meet with various communities, GCM utilized multiple methods to establish these group activities. In South Africa, GCM staff identified a venue and worked with a local partner to gather women from specific groups, such as sex workers, migrants, young women, and professionals. For instance, GCM attempted to: establish interactions with health care professional organizations to discuss their specific role in introducing new HIV biomedical prevention technologies, meet with sex workers to discuss their increased risk of HIV and how they might use a microbicide, and meet with women at hair salons to learn their stories and experiences.

Kenya staff sought outlets where they could meet with both women and men. Staff worked directly with low-income women at increased HIV risk, but also hosted "Science Cafés" where staff would identify university women who are considered trendsetters in their communities and could act as a potential gateway to microbicide introduction. Kenyan staff also adapted the PRA model to include men by participating in community parliaments (male-only gatherings to discuss local issues) where they discussed microbicide introduction and protecting women. Through these discussions, staff learned more about the types of HIV protection men prefer to use and about their experiences with sex workers.

Efforts in Zambia were concentrated in Lusaka and gathered very diverse audiences. Sessions were conducted with sex workers, HIV-positive communities, elderly communities, traditional leaders, and co-ed groups. Staff also networked with local partners to identify group members and host events. In order to meet with women in low-income, high-risk settings, GCM arranged for "African Water Cooler Gossip" sessions, where staff gathered women near water collection sites (taps), which are typically women-only sites, and hosted candid discussions about their lives. Furthermore, a GCM staff member conducted an advocacy mobilization forum, where she gathered together civil society members, advocates, local organizations, and policymakers to discuss and encourage future microbicide advocacy work in Zambia.

GCM utilized the story-telling technique in each country to allow the facilitator to relate to the group and develop a safe and comfortable environment for group members to discuss their sexual behaviors and experiences, their opinions on HIV, and their thoughts on prevention methodologies. Using this technique, GCM staff members would begin by telling a personal story about their HIV risk to create a safe environment where group members could discuss their

experiences, their thoughts, and their desires for new prevention technology and implementation strategies.

As GCM developed its activities, staff discovered that in some groups the understanding of HIV prevention and transmission was low. Therefore, GCM modified its strategy to assess the level of understanding of HIV prevention, the life cycle, and awareness of new technologies so that participants would not miss an opportunity to learn how to protect themselves. This was also helpful in identifying potential advocates for microbicide introduction.

GCM used these activities to gain perspectives from a variety of audiences. The goal was to work with audiences from high-risk populations, especially women of varying ages, professional backgrounds, and marital status. In support of this goal, GCM actively worked to establish and cultivate local partnerships with community groups that have access to target audiences. These relationships were critical to GCM's ability to gain access to specific communities because it allowed GCM to establish trust with group members. Furthermore, these opportunities allowed GCM to have continued contact with community members and partners to maintain updates on microbicide research and to establish microbicide champions in the field.

Gender Dynamics and Practices Highlighted in Dialogues

Kenya, South Africa, and Zambia are three separate countries with unique cultural practices, languages, governments, and gender dynamics. The participants in each discussion group identified the gender, cultural, and physical practices that they believed place them at greater risk of contracting HIV in addition to describing specific points of entry and access for microbicides to support their willingness and ability to use new products. Moreover, participants described their ability to negotiate for safe sexual practices; discussions were concluded by gathering the participants' opinions on how to overcome the limitations that make it difficult for women to engage in safe sex. Through GCM's dialogues, both women and men discussed the issues of violence against women, women's poverty and financial dependence on men, and peer pressure on women to remain in unsafe and/or unhealthy relationships. These dialogues provided valuable insights into the participants' perspectives on the gender-specific contexts and dynamics in their communities that increase their risk of contracting HIV. In short, GCM learned that microbicide implementation programs in these communities will need to address certain social, economic, religious, and other practices; empower women to advocate for their own safety and health; and exist within the dictated role that women fulfill.

South Africa Experiences and Practices

GCM entered multiple communities within the Johannesburg, Durban, and Cape Town areas to learn more about potential end-users' experiences with HIV prevention tools, to understand gender balances, and to educate the community about microbicides. Within each of these provinces there are unique differences between various communities and within women's varying roles as mothers, professionals, sex workers, and more, which will impact their ability to utilize microbicides.

Within Johannesburg, GCM engaged communities in Diepsloot, Soweto, Hillbrow, and Klerksdorp. The first community dialogue in Johannesburg was hosted in Diepsloot, where a GCM staff member collaborated with Zizanani, a local community outreach NGO. This dialogue drew together ten women from ages 23 to 56, most of whom were married, although there were some single mothers and two grandmothers. GCM utilized the story-telling technique to facilitate a dialogue for the women to discuss their perceptions of risk of contracting HIV by using their personal experiences as a foundation. The participants described their experiences and expressed that alcohol abuse among men, poverty, domestic violence, and rape were contributing factors to their increased HIV risk. One woman stated, "I wish the gel could be available soon—our daughters are being raped on their way to school. These thugs are taking our girl children's virginities." These participants felt that men's alcohol abuse limits women's ability to advocate for condom use; additionally, they reported that men will drink in local taverns where they will engage in unprotected sexual activities with sex workers.

The Diepsloot participants acknowledged issues of women's dependence on men, which places them at greater risk of violence or relationship expulsion if they attempt to negotiate for protected sex. Given women's dependence on male partners in their community, they are left with few or no options to protect themselves. Moreover, participants identified male dominance issues in their relationships that would limit their ability to speak to their partners or share the information learned from the workshop because they risk physical abuse. One participant said that 'if we go home and impart some of the knowledge from the workshop it could seem that we are trying to outsmart our partners, or lying to them in order to get them to change their sexual behavior." These women expressed urgency for local and global organizations to educate men in the community about microbicides because they did not feel that they would be able to do so. Finally, the women discussed the prevalence of rape for young girls and elderly women in their community; these participants expressed a need for daily microbicides because women never know when they may experience sexual violence, and this will ensure that they are always protected. One woman said, "Diepsloot is a very close-knit community. It is very difficult to have any privacy even in your own home. Many families live in overcrowded shacks, and the use of microbicides would be very difficult to conceal. The packaging would be obvious, and there are very few places in the home where a woman would be able to store the gel out of reach of very inquisitive children and adults. Even those who are HIV positive cannot hide the fact that they are taking medication." Ideas and statements like these indicate that the women are willing to use microbicides; however, market developers must be considerate of the packaging and storage needs of their users to ensure that women are able to store the products prior to use.

"We have not heard about microbicides in our community—we have only heard about it in the news, on TV, and on the radio. We need more workshops like these, so that more people are aware of what microbicides are and how they work."
~Female participant, Soweto, South Africa

In the other Johannesburg districts, GCM staff documented similar discussions with women and men simultaneously. On Human Rights Day (March 21, 2012) in South Africa, GCM hosted 15 married and long-term heterosexual couples ranging from age 25 to 60 in Soweto and asked them to share their concerns about gender-based violence and the role that alcohol abuse plays in these situations. Participants spoke of sexual norms that expose women to increased violence and the fear of speaking out for help; they also identified the financial dependence that women have on men. One participant stated, "Our culture allows men to have

multiple sexual partners while women are expected to be faithful. They are called names and ostracized by the community if they are found to be unfaithful." During a discussion about the varying forms of microbicides, participants expressed different desires. Some preferred the idea of the ring over the gel because they would not have to insert it every day, but some male participants expressed concern that they may feel pain with the ring. Additionally, the participants were unanimous in their agreement that microbicides should be sold from supermarkets, family planning clinics, and pharmacies for no more than 60 US cents, adding that microbicides should be available free of charge from government hospitals and clinics. Finally, the participants discussed the importance of educating the community in order to accurately assess the impact that microbicides will play in end-users' lives.

In the Hillbrow community, the dialogue included 28 women and 2 men ranging from age 26 to 60 from refugee centers. During this workshop, participants expressed a desire to have microbicides available specifically in refugee centers and family planning clinics, as these participants have either experienced or witnessed friends and family members being denied antiretroviral (ARV) treatment from certain health care facilities after being recognized as foreigners. As a result, these participants were concerned about their ability to access microbicides if they were not dispensed at refugee centers. Moreover, participants felt that microbicides should be available free of charge from refugee centers.

"If a man is paying your rent and buying food for your children and says he wants unprotected sex, you cannot say no."
~Female participant, Gugulethu, South Africa

The final Johannesburg dialogue was hosted in Klerksdorp in collaboration with the Midwives AIDS Alliance. GCM staff met with 24 participants—all were senior midwives, midwifery managers, midwifery university lecturers, nutritionists, or dieticians who practiced in health care facilities and universities. The participants listened to two presentations on the HIV life cycle and the microbicide clinical trials; afterward, the participants were engaged in a discussion of their insights into how microbicides may be implemented in their communities. The participants expressed that antenatal clinics could offer optimal space for microbicide introduction, and the midwives felt that they could play an important role in HIV prevention. The participants also expressed a concern about overburdening health care workers, who presently struggle to maintain their current paperwork and learning about new health policies and practices. One participant said, "Communication channels need to be improved among all stakeholders in HIV prevention. Quite often health care workers are left out of the discussion, and yet we are expected to implement these health policies and programs." Finally, the participants stated that if nursing students could attend microbicide training, they could better support health facilities in microbicide implementation. When presented with the varying microbicide delivery forms, participants felt that oral pre-exposure prophylaxis (PrEP) provided the best option because it would not make the women "wet." One participant stated, "PrEP is a great idea—women will have the power to protect themselves from HIV. However, we need to address the issue of gender-based violence. Some men are controlling to the extent that they will monitor what tablets the woman is taking."

The community dialogues in Capetown were focused in the Gugulethu Township, where GCM hosted three unique sessions. For the initial dialogue, GCM collaborated with the Desmond Tutu Research Foundation and the Sex Worker Education and Advocacy Taskforce (SWEAT) to gather 25 female commercial sex workers from age 25 to 48 to discuss their

understanding of HIV prevalence within their community. These women identified their personal vulnerabilities and experiences with violence; from their experiences, women highlighted that some clients refused to wear condoms, and said if the women insisted, they could be raped or physically abused. Moreover, some women noted that they can earn more money for engaging in riskier sexual activities. When the women shared their personal stories about engaging in transactional sex, nearly all cited poor socio-economic conditions in which sex work is the only means of survival. Through the women's stories, it is clear that they desire access to HIV prevention options that more adequately suit their lifestyles, and that they need an option to protect themselves if they are raped or if they are forced to have unprotected sex. Even though the women face a number of issues that limit their ability to protect themselves, they are still willing to identify ways to overcome those issues. The discussion concluded by asking the women for their opinions on best options for accessing microbicides – the group identified local mobile clinics and family planning clinics. Additionally, they felt that accessing these products at local pubs, night clubs, and truck stops would further encourage their consistent use. Finally, the women stated that these products needed to be available at a very low cost, if not free, in order to encourage their personal purchasing and use.

For the next Capetown dialogue, GCM again collaborated with the Desmond Tutu Research Foundation and SWEAT, this time to introduce microbicide researchers from the National Institutes of Health (NIH) and USAID to five female sex workers from age 25 to 38 at the home of one of the sex workers. The purpose of these activities was to engage microbicide researchers in a discussion with potential end-users about their lives, their understanding of HIV and prevention strategies, and their perceptions of access and desire to use microbicides. The women expressed concern about their lack of understanding of HIV prevention and new technologies and described their experiences with rape and violence, which increased their risk of contracting HIV. Moreover, the women expressed their need to access products that they can use in advance of or immediately after sexual encounters to protect themselves. One woman said, "Sometimes business is slow on the streets and if you are desperate for money and a client says he wants unprotected sex, you just have to do it so that you get money to buy food." As far as points of access, this group wanted to access microbicides at family planning clinics so they can purchase them when they receive their contraceptives, but also at other safe places including weekly sex worker meetings. The women also identified cost as a contributing factor; they stated that microbicides need to be inexpensive in order to ensure that women will continue to purchase and use them.

"PrEP is a great idea—women will have the power to protect themselves from HIV. However, we need to address the issue of gender-based violence. Some men are controlling to an extent that they will monitor what tablets a woman is taking."
~Health care professional, Durban, South Africa

GCM again collaborated with the Desmond Tutu Research Foundation for the final Capetown dialogue, which occurred in a hair salon with three HIV-positive women from age 25 to 30. This event allowed additional guests from NIH and USAID to learn about young women's lives and their opinions on microbicide implementation strategies. The women shared their stories of how they contracted HIV, their experiences with rape and intimate partner violence, and their dependence on the charity of others for food and shelter. One woman described that she was initially tested for HIV when she became pregnant and that the result was positive; when she shared her status with her partner he became physically abusive. The participants continued to describe experiences of stigma for engaging in sexual activities at young ages when they

attended family planning clinics; the health care providers refused to provide condoms because they were so young. They also highlighted their inability to afford public transportation to the clinics so they depend on mobile clinics for contraception and condoms. The women felt that mobile clinics would provide positive access points for distribution because they could receive their microbicides discreetly. The women liked the idea of using a ring because they could insert it and not have to worry if they engaged in unplanned sex, but were concerned about it becoming dislodged or lost in their bodies. They also liked the gel because they could just insert it when they wanted to have sex. Through their stories, these women shared similar experiences to the sex workers about partner violence and limited financial means; they also expressed similar desires for points of access to avoid stigma and a need for low cost to ensure use. It is important to note how women from the various communities have described similar stories of the significant role gender-based violence has played in their ability to protect themselves from HIV, but also their desire to develop solutions that will assist in implementing new HIV prevention tools.

GCM's also conducted events in communities within Durban. The first workshop was held with 50 professional midwives from health care facilities and universities. During this discussion, the professionals expressed their concerns that a gel will make women too wet during sex and, given sexual practices, men will complain. The discussion concluded with the health care professionals expressing their opinions on the need for better education and consistent updates on HIV prevention technology to communicate with their patients. Similar to the previous dialogue with health care providers, participants expressed concern for overburdening the system by dispensing microbicides through the health care system. One participant stated, "The system is already overburdened with sick people—how are we expected to cope with healthy people also accessing the same facilities?"

The final GCM event was a workshop hosted in Durban for 28 participants including civil society members, community advocates, and other HIV stakeholders. Participants were presented with a solid understanding of HIV prevention research and an update on current trends in microbicide trials. During the open dialogues, the participants expressed that microbicides should be accessible through health centers and family planning clinics or over the counter at pharmacies to protect women's privacy. Additionally, they felt that microbicides should be offered free of charge or at a low cost (equivalent to a condom) in order to ensure that individuals can afford it.

A recurring theme from all events was the issue of violence against women. Participants expressed great concern over women's inability to access or ask for HIV prevention methods when they risked abuse or rape from their partners. A majority of the dialogues revealed stories from at least one participant of rape or violence due to HIV prevention negotiations. These stories reflect gender imbalances between women and men, especially when discussing sexual activities and safer sex practices. Even though some women are in a position to control sexual practices, others are vulnerable because they feel that the only survival option is to engage in risky transactional sex. If women are able to discreetly use microbicides, they may be able to avoid certain occasions of violence or to at least know that they have some form of self-controlled HIV protection.

The participants repeatedly requested more efforts to educate the community, especially the male members of the community, about future microbicide use in an attempt to encourage broader awareness and understanding so that men will support women in using these products. Moreover, there is a need for more information and microbicide research updates to reach these

communities. As one participant said, "I can't say if I will use the gel or not—I need to know how effective it is first. At the moment I am not confident that I will use a gel which is not 100 percent effective. I want to use a product that I can rely on 100 percent. What is the point of using this product and still get infected?" It is important to continue educating communities and encouraging all community members to protect themselves through any means possible.

It is imperative to learn more about the stigma associated with HIV and using HIV prevention options so that the appropriate packaging and points of distribution can be prepared; women were concerned about people witnessing their purchase of HIV prevention products and stigmatizing them for this. Distributing microbicides from a neutral and discreet source will encourage their use. Finally, there were varying responses to using different microbicide applications (i.e., gel, ring, injection) and further research is needed to understand how each applicator can appropriately fit into women's lives.

Kenya Experiences and Practices

GCM conducted eight community dialogues throughout Kenya in areas including Korogocho, Kisumu, Thika, Nairobi, Kericho, and Mombasa. Each dialogue targeted a specific audience, such as sex workers, local township women, university women, and male-only groups. The purpose of these activities was to learn more about the potential end-users' experiences with HIV prevention tools, to understand gender balances, and to educate the community about microbicides. These dialogues identified a number of points of entry for communities to introduce microbicides, in addition to highlighting the need to continue to educate the male population to support women in using new products.

"I had been hearing rumors from my friends that my husband was having an affair with another woman from Tanzania. He also used to come home drunk all the time. When I attempted to negotiate for condom use with him, he refused, and in the process he infected me with HIV."
~Female participant, Nyanza, Kenya

GCM conducted a number of workshops in the Nairobi area, including within the city and the informal settlements that have developed in its surroundings. GCM held two discussions with women in Korogocho in order to learn the participants' perspectives on incorporating microbicides into their sexual lives. The first discussion consisted of 20 female participants from age 22 to 30. Participants identified alcohol and drug abuse among men, violence against women, poverty, multiple concurrent relationships, and sexual exploitation as contributing factors that place women at greater risk of HIV. One woman announced, "Some of our husbands are drunkards, and wherever there are drunkards, there are sex workers." Another woman described how one toilet is shared by 20 households in her community, and if women and girls try to use this facility after dark they can be waylaid and raped. Women shared their stories about engaging in survival sex (using sex as a method to earn money) to ensure they could feed their children. One woman shared her experience with an employer offering to double her pay to US$1 if she agreed to have sex with him. With regard to the microbicides, these women demonstrated equal preference for the ring and the gel and agreed that they would not inform their partner of their microbicide use to prevent violence. "No, I will not tell him, it might bring violence in the home. I will also not tell him because it might show that I do not trust him." Another woman shared similar sentiments, "I would not tell him because he will think that I use the gel with other men too, which might lead to violence in the home." During a discussion of points of access and cost, the women identified the municipal clinic as the

best option and said that it needs to be free; one participant said, "We share malaria tablets and even condoms. Even for these microbicides, women will borrow the gel from me if I have it."

The second story-telling dialogue in Korogocho was in collaboration with the Liverpool VCT Care and Treatment Clinic and the Bar Hostess Kambi Moto Community Group, which hosted 20 female sex workers from age 22 to 30. These women discussed how alcohol and drug abuse, religion, rape and crime, and lack of condom use contribute to their HIV risk. The women commented on how Catholics and Muslims are discouraged from using condoms. When discussing rape, one woman said, "Since most of the young men who hang around the alleys know that you are a sex worker, they will rape you since they know that you do not have a husband." Another woman shared her experiences of earning higher pay for sex without a condom, saying, "There are instances where the client can wear a condom and then deliberately tear it or pull it off, or refuse to wear it completely. Sex with a condom will earn me US$2. Wherever you go, all things are expensive and this money will not be sufficient to cater for my needs and my family. It is usually a difficult decision. Sometimes we have unprotected sex by faith and take the US$5 because the situation forces you to. You look at the challenges in your life and you just have to take the money. It is very difficult." As for the form and distribution of microbicide, most participants preferred the ring to the gel—with one woman saying, "I prefer the ring because I might be in a situation where I cannot insert the gel, for example, in instances of rape where I cannot negotiate for a chance to insert the gel"—and would rather obtain these products from the municipal clinic.

These dialogues allowed the Korogocho participants to describe their experiences and express their concerns and ideas regarding how to protect themselves. Through these discussions, the participants identified the difficulty they have in negotiating for safe sex on their own behalf. Furthermore, when prompted about access, participants stated that, due to stigma, they wanted to access microbicides through the municipal clinic because it would be discreet, and they would not feel like they were being judged. Moreover, the women stated that if microbicides needed to be purchased, they needed to be at very low cost, e.g., 25 US cents, because they would not be able to afford them otherwise.

"Married women need something to protect themselves because while they remain faithful to their husbands their husbands have smaller girls who have other boyfriends as well."
~Female participant, Mtendere, Zambia

The first Science Café was organized in collaboration with The Kenya Legal and Ethical Issues Network. It was held in Nairobi with 11 professional women involved in diverse socio-economic fields who are considered trendsetters in their communities because they are educated and building long-lasting careers. Group members discussed their experiences with HIV testing and their ability to use condoms. One woman described a discouraging experience with the Voluntary Counseling and Testing (VCT) clinic: "I have been tested by force because I was pregnant and did not like the way that they did it—they sent the results by snail mail and the results were opened by my husband since he is the one who collects the mail. I have never gone to VCT since. I expect the person that I am sleeping with to tell me whether he is HIV positive or negative." The women expressed excitement and willingness to use microbicides when they are available. One woman stated, "I would use it but not disclose it to my partner because the tool is supposed to empower me. I would, however, share this information with my female friends." In contrast, other women felt that they would disclose to their partners that they were using a product: "I would use a microbicide. I would share with my colleagues and I would also share with my partner. However, I would have to

explain it to him tactfully," stated one woman. Another said, "I would use it and would disclose it to my partner, my friends, and my workmates." In one dialogue, women identified a need to sometimes disclose and sometimes not. Women will adapt the use of microbicides to best fit their needs within their circumstances; the important piece is that they will share the information with their friends and colleagues because it will help raise microbicide awareness and encourage use.

GCM conducted a second Science Café in Kisumu to engage university women in similar discussions about their ability to protect themselves and their understanding of places to access HIV prevention information. Similar to the Nairobi participants, the women highlighted the issue of how condoms are associated with trust in their relationships. They described how condom use is a "taboo" subject with their partners—one that is usually avoided. The women mentioned how condoms are used for the first few days but said that quickly there is "an assumption of negative status" that ends condom use, even if the HIV test has not been returned yet. As the relationships progress, condoms become infrequent because trust is established between the partners. Finally, these participants reiterated that they learn the most about HIV and sexual health through their circle of friends and media platforms.

Other story-telling dialogues were conducted in Kisumu and Mombasa with low-income women to learn about the participants' perceptions of risk. The Kisumu event was held in collaboration with the Community Outreach Unit, Research Care and Training Program from the Kenyan Medical Research Institute–University of California, San Francisco (KEMRI-UCSF) and hosted 20 female participants from age 22 to 30. Similar to previous discussions, the women shared their experiences with HIV prevention tools and their personal preference for various microbicide applications. One woman stated, "The religious leaders discourage condom use, saying that if you use condoms then it means you are promiscuous," which makes it difficult for her to negotiate for condoms. Another woman described how her mother-in-law encouraged her to remain in her marriage despite the constant infidelity and violent spousal abuse. Her mother-in-law told her, "You just persevere and stay on in the marriage. Those other women are just jealous of you. They want your marriage to break down and want you to leave the home so they can take over. Just be quiet and let life go on." Another participant described an experience with her boyfriend that turned violent after she had returned from the reproductive health clinic with condoms. The woman reported that her boyfriend said, "Why are you carrying condoms? It is only prostitutes who carry condoms in their handbags." As the dialogues continued, the women shared their preferences for the ring and gel. "I prefer the ring because it is discreet. I can have it inside and my partner will never know, but if it is the gel he might eventually find out because every time we want to have sex I will be having to excuse myself to go and insert the gel." Another woman preferred the gel because it "would act as a lubricant when I am not so well prepared for sex."

The Mombasa story-telling event was held in collaboration with the Government of Kenya–Ministry of Youth Affairs Likoni Constituency and hosted 20 female participants from age 22 to 30. Similar to the Kisumu event, the women expressed issues with religion not condoning condom use. Additionally, participants described how long-distance relationships over long periods of time make it difficult for men to abstain from sex. The women also preferred the ring because "I don't have to tell my husband. Here in Mombasa you have to ask your husband permission to do everything. With the ring, he will never know." Finally, the women expressed their gratitude for learning about microbicides. Said one, "I have heard about microbicides

before although very vaguely, but today I have come to understand it better and also the ways in which it can be used."

In order to ensure that GCM achieved a well-informed understanding of microbicide introduction, it identified opportunities where staff could engage male members of communities in male-only spaces to have candid discussions about sexual practices and microbicide use. GCM arranged for community parliaments in Thika and Kericho to engage male participants in a discussion about their perspectives on microbicides, women, and sexual practices. The Thika event was held in collaboration with Partners in Prevention for 12 male participants from age 22 to 36. The men described their feeling that long-distance relationships made it difficult for them to abstain from sex. One participant described how he found it difficult to sleep alone after driving his truck between Thika and Mombasa (approximately 550 km). After such a long journey, he found transactional sex necessary. The men also discussed how women offer to have sex with them in exchange for transportation, pocket money, and other resources or services. Moreover, the men described how most of them were in multiple concurrent relationships and said that when their spouses learned of these relationships they would also seek other sexual partners.

"Sometimes when we carry these women home with our motorbikes, they keep on touching our bodies suggestively. When you eventually reach your destination, they invite you to the house and enter the bedroom and then call you to get your money. When you enter the bedroom you find them on the bed naked waiting for you and at that point, it is difficult to resist and you may even end up having unprotected sex."
~Male participant, Thika, Kenya

Similarly, GCM collaborated with KEMRI–Walter Reed Project to host a second community parliament in Kericho with 12 men from age 20 to 32. The men described how Kericho is a rich agricultural town providing lots of field labor opportunities for women, saying that when women need support in the fields, they will exchange sexual favors for assistance. Furthermore, one participant explained that he has to travel long distances to purchase condoms so that he will not be recognized, because the local shopkeepers were aware that he was married and would initiate rumors that he was unfaithful. Other participants acknowledged this experience and stated that they did not want to use government-issued condoms because the perception is that they are "low-quality." At the conclusion of the discussion, the men described their support for women using microbicides. One said, "It is important to engage men in such discussions and I am very happy that these discussions are taking place. In a relationship, the health of a woman will affect the man directly or indirectly."

Both of these events provided valuable insight into the male participants' perspectives on HIV risk to women and microbicide use. Both groups identified women's poverty, men and women's multiple concurrent relationships, and stigma/judgment when purchasing condoms as contributing factors to HIV. Participants shared their stories of their inability to resist women when they are away from their homes for long periods of time. Participants also described how women engage them in unprotected sex in exchange for transportation or money because of their impoverished circumstances. Moreover, the men described their excitement about learning about microbicides and how they can support women. One man said, "If men are empowered, they can assist the women to use the microbicides and even hopefully have a situation where you can see men carrying the gel for their partners." These dialogues provided a strong contrast to the female-only discussions. None of the men mentioned any instances of violence or abusing their

partners for requesting condoms, but they did mention their willingness to support women in microbicide application and use if they receive more education and support.

The final Science Café, hosted in collaboration with KEMRI, occurred in Kisumu with 26 female participants from tertiary colleges. The women shared their fears about being tested for HIV. "I have never been tested. I fear knowing my HIV status and would rather stay without knowing. If I knew that I had HIV, I think I would die very fast," one woman said. The participants also acknowledged how condom use decreases when they are in a relationship due to the assumption of negative status. The participants did discuss the use of female condoms, but only two women had experience using that condom and felt that it was cumbersome and difficult to insert.

Although each participating woman is unique and her experiences pertain only to her life, certain themes recurred in dialogues hosted across Kenya. During most of these dialogues, women frequently expressed their inability to negotiate for safe sex because they could be subjected to violence. Second, both male and female participants stated that multiple concurrent relationships were frequent areas of concern for them. Third, participants discussed their fears of being stigmatized for being HIV-tested and/or for purchasing condoms. Fourth, participants in most of the dialogues mentioned the issues of poverty that contribute to women's relationships and experiences that place them at greatest risk. Additionally, some women struggle with negotiating for condom use and therefore do not feel that they can advocate for microbicide use, but would use these products discreetly. Issues of rape and religion also were mentioned in different dialogues, with women describing how condoms are not used in these settings, but saying that a ring would allow a woman to protect herself. Also, women frequently expressed the desire to obtain their microbicides from the municipal clinics to ensure that they could avoid stigma and be discreet.

Similar to South Africa, Kenya has significant issues with gender imbalances and violence against women that will make microbicides essential. Participants also felt that it would be important to provide education and awareness, especially for male community members, to support their ability to use these products. Male participants were excited to learn about the opportunities that microbicides will bring and expressed excitement about supporting women in their use. University women are willing to teach their friends, colleagues, and families about the products; moreover, some women are even willing to disclose the use to the partner. Overall, the responses from all of the groups demonstrate excitement and willingness to use the products when they become available, now that they are aware. Microbicides will not solve the violence associated with safer-sex negotiations; however, some participants felt that greater education and excitement over new products may reduce certain instances of violence.

Zambia Experiences and Practices

In Zambia, GCM conducted activities in communities in the Lusaka province, where a GCM staff member utilized the story-telling technique in Kanyama, Bauleni, Mtendere, and Tasintha compounds and piloted the African Water Cooler Gossip program in Misisi and Garden Open compounds. Similar to the South Africa and Kenya programs, the goal was to learn more about the potential end-users' experiences with HIV prevention tools, to understand gender balances, and to educate the community about microbicides.

"We need to stop certain practices, like dry sex."
~Female participant, Kanyama, Zambia

The participants from both the Kanyama and Bauleni dialogues

mainly focused their discussion on how the practice of dry sex may serve as a strong barrier against using microbicide gels. Participants were concerned that if their partners found them to be "wet," they would assume they were unfaithful and either abuse the women or leave them. Both of these discussions included men and women. The men expressed their enjoyment of dry sex, including one man stating, "You must feel like you are conquering that vagina." Another male participant stated that if he found his partner's vagina wet before they had sex, he would assume she was promiscuous. The women expressed a need for men to receive more education and to support one another to discourage dry sexual practices; additionally, one female community elder expressed that "men can encourage other men" in supporting women's use of microbicides. Finally, the group unanimously stated that microbicides needed to be offered free of charge in order to encourage their use.

The Mtendere story-telling event provided numerous discussions of contributing factors to women's risk of HIV. GCM staff met with 17 female participants from age 19 to 40 and asked women to share their experiences with preventing HIV. Participants described how men partake in multiple concurrent relationships, but women are pressured to remain with their husbands regardless of infidelity or risk to their health. One woman said, "Married women need something to protect themselves because, while they remain faithful to their husbands, their husbands have smaller girls who have other boyfriends as well." Another woman felt a microbicide would help her, saying, "In case my husband cheats on me again, I would have protected myself by using microbicides." Furthermore, participants identified alcohol abuse, which can result in men having unprotected sexual relationships with sex workers and young women. The participants also commented on their financial dependence on men, which can limit their ability to advocate for safer sex practices, in addition to prohibiting them from abandoning relationships that are not safe for them. Finally, participants described the significant role the *alangizi* (traditional marriage counselor) plays in their coming of age as they prepared for marriage. The *alangizi* will teach them special concoctions that will reduce their vaginal secretions and advise them in specific activities to sexually satisfy their husbands.

Participants in the Mtendere compound group, similar to the Kanyama and Bauleni compounds, demonstrated similar concerns of gender imbalances. One participant, who is a nurse, stated, "The community's family planning services only became effective when men were educated about them." Microbicide implementation will require greater education for male members of the community, as well as working with traditional leaders to receive their encouragement in supporting microbicide use in this community. This compound's discussion made strong references to tradition, especially the role of the *alangizi* who instruct women in specific methods to preserve the marriage. Finally, women discussed that microbicides should be accessible through local family planning clinics and youth centers and should be free; however, women did acknowledge that if microbicides could not be free, then they should not cost more than condoms.

"It was better for me to get infected with HIV as long as I could go home and feed my children."
~Former sex worker, Tasintha, Zambia

The Tasintha story-telling event, with 15 former female sex workers from age 20 to 40, produced discussions about how poverty, violence, cultural traditions, and alcohol abuse are significant contributing factors to their personal risk of contracting HIV. Participants described how they engaged in sex work to alleviate their impoverished circumstances because they felt that they had no means to earn a decent income that would enable them to buy food for their

families or even pay house rentals. One said, “If I have not had a client the whole evening and one client shows up and demands sex without a condom, I cannot refuse because otherwise I will have to go to sleep hungry.” Some women expressed that the only option they had was to engage in sex work, which sometimes left them beaten and/or raped. Finally, the women described their experiences with dry sex and participating in dry sexual practices to avoid marital or partner abuse. One woman said, “Most men believe if a woman is lubricated during intercourse she has either been sleeping around or trying to practice witchcraft.” Like the other discussion, this dialogue concluded with the participants suggesting the use of mobile dispensing facilities that would drive through communities to ensure that women received the products. Moreover, the women recommended that microbicides be free or that the government partner with NGOs to provide these products at a minimal cost.

The African Water Cooler Gossip events in Misisi and Garden Open presented similar discussions during the story-telling events. The Misisi event hosted 34 female participants from age 19 to 49. The participants highlighted the issues of traditional teachings, which encourage women to respect and be submissive to men. The women also described their experiences with transactional sex. One woman said, “How can I keep my children hungry when there is another man willing to give me money for food if I am in a relationship with him? Others engage in this vice because they know their husbands are sleeping with other women and they can’t trust them to use condoms.” Women commented that there is a tradition of subservience and a widespread practice of dry sex, which can place women at greater risk of HIV transmission because certain methods used to dry and tighten the vagina may cause reactions, including inflammatory response and epithelial damage that may increase HIV transmission to women.[23] The participants expressed a need to sensitize the community (both women and men) to microbicides to support women’s ability to access and use these new products. Similar to the other dialogues, these women agreed that microbicides should be offered for the same price as condoms, to ensure their use, from community centers and clinics.

The African Water Cooler Gossip event in Garden Open was conducted with 30 female participants from age 19 to 45. The participants identified issues of poverty, multiple concurrent relationships, and traditional practices that increase their vulnerability to HIV. Women made statements such as, “Many women in this compound do not mind sharing men; there is no guarantee that my husband will remain faithful to me, so I need something to protect me from HIV” and “A real woman according to this community should remain in her marriage even if it causes her harm, if the husband sleeps around or refuses to use condoms.” In this community, women feel pressure to remain in relationships that place them at risk, so they desire options to protect themselves. Another participant expressed her experience with transactional sex, “We don’t go out looking for sex—we go out looking for food and shelter for our children.” At the conclusion of this event, a woman expressed a need for more education about microbicides, saying, “People in this community are still very ignorant and need to be sensitized on important issues such as HIV prevention.” As in the other dialogues, these participants suggested that microbicides be made available through clinics and community centers for the same cost as condoms to encourage their purchasing of the products.

“A real woman, according to this community, should remain in her marriage even if it causes her harm, even if the husband sleeps around or refuses to use condoms.”
~Female participant, Garden Open, Zambia

The reoccurring themes in dialogues hosted in Zambia included the practice of dry sex, women's poverty, and women's roles in relationships. Participants identified their concerns of multiple concurrent relationships and peer pressure to remain in marriages that experience violence or health risks. The gender dynamics are encouraged and perpetuated in a number of ways. First is the practice of dry sex, which places women at greater vulnerability to HIV.[23] If women are found to be "wet" they are considered promiscuous, but if they are dry they place themselves at increased biological risk of transmission of HIV. Moreover, women's poverty and inability to refuse or abstain from unsafe sex due to their need to feed their children and/or pay their bills perpetuates these gender imbalances. Similar to participants in South Africa and Kenya, none of these participants identified concerns in their ability to access HIV prevention tools—the issues in using existing HIV prevention methods were due to violence and gender dynamics. Moreover, female participants said they would like to use microbicides, but their ability to do so will be dictated by the cost, point of access, and their partner's preference for dry sex. The women participants provided valuable insights into implementation opportunities that should be included, such as considering the role of the *alangizi*, increasing educational awareness opportunities for men, and the role that traditional practices play in sexual relationships.

Country Comparison

While statements made by participants do not necessarily apply to larger populations, we note that many similar themes emerged during the dialogues held by GCM staff in each country. These themes will be relevant to those exploring potential barriers or incentives to future microbicides introduction, and should be studied further through qualitative research methods. Repeated participant-identified contributing factors for HIV risk across the three project countries include:

- Violence against women
- Poverty
- Multiple concurrent relationships
- Lack of microbicide awareness

All of these issues are specifically related to the gender dynamics occurring within these communities. Violence and poverty appear to be the two most critical factors the participants identified; they felt that their lack of financial independence greatly limited their ability to negotiate for safer sexual practices, which in some cases can result in intimate partner abuse. Moreover, multiple concurrent relationships combined with impoverished circumstances can limit women's ability to leave relationships where their partners expose them to HIV risks, but women also trusting that their partners are monogamous and HIV-negative can also increase their risk of transmission. Women also stated that as intimate relationships advance, they are less likely to use a condom because trust is being established. Finally, in all of the activities, both women and men expressed that they lacked appropriate knowledge of the various HIV prevention methodologies and were unaware of any new prevention tools in development; there was a repeated call-out for greater educational opportunities for men. The participants expressed a need for improved education from a variety of sources in their community to support their full awareness of the HIV life cycle and prevention options.

Women shared their opinions that the best points of access for microbicides would be from family planning clinics, municipal clinics, and mobile clinics. Wherever women can

receive contraception would be a good source to obtain microbicides, because they can remain discreet to avoid stigmatization from their community. Additionally, participants emphasized that the cost of microbicides had the potential to impact access; participants stated that they would purchase microbicide products as long as they were the equivalent cost of a condom, although many participants felt that microbicides should be provided free of charge.

"People in this community are still very ignorant and need to be sensitized on important issues such as HIV prevention."
~Female participant, Garden Open, Zambia

Gender dynamics will play a critical role in women's ability to use microbicides. Participants' descriptions of engaging in transactional sex for food and stories of being raped and having unprotected sex to avoid intimate partner violence are crucial in understanding the important role a microbicide will play in these women's lives, but also the barriers that women may face in using new products. The best method for using microbicides is to combine use with a condom. However, in cases where women have no other option, microbicides will provide some form of protection against HIV infection.

As demonstrated in this report, all three of the countries in which GCM conducted activities struggle with issues of violence against women and gender inequity. The lessons learned from talking with end-users can provide valuable insight into the potential limitations and areas of encouragement for microbicide implementation. Specifically, it is important to understand the complexity of HIV prevention methods for women and the contributing factors that limit or enhance their ability to use them. First, women describe their experience of trust in relationships, and how trust is sometimes demonstrated by not using HIV prevention tools. Furthermore, there is a lack of awareness of the existence of HIV prevention products. Also, communities will respond differently to these products—in some areas men will be supportive of women's use, but in others there may be a lack of support. Religion was mentioned because certain faiths do not support women and men using condoms, but it is unclear how this will affect microbicide use. Women expressed a range of feelings about their ability to negotiate for safe sex with their partners, and whether they would inform their partners about microbicide use. There are a number of areas that require further exploration to identify key points of success and limitations for microbicide implementation.

In order to develop a microbicide implementation gold standard, it is imperative to understand gender dynamics within each country as well as specific areas of stigmatization, socio-economic issues, religious influence, and sexual practices/behaviors. We must also learn directly from the potential end-users what will encourage or limit their ability to use microbicides.

"Sometimes business is slow on the streets and if you are desperate for money and a client says he wants unprotected sex, you just have to do it, so that you get money to buy food."
~Female sex worker, Gugulethu, South Africa

Next Steps

Although these comments are the opinions of only a few community dialogue participants, it is essential to consider thoughts and ideas from potential end-users when developing a microbicide implementation strategy for these countries. Similar themes may emerge from many communities, and these themes can be used as a foundation for introduction programs while still keeping in mind that sexual practices and gender balances are unique in each community and country. Therefore, future implementation programs will require

specific tailoring to ensure initial and long-term success. Further implementation research will be needed prior to and following microbicide introduction to understand the real impact that gender and other issues play on women's ability or desire to use a microbicide.

Many of the overlapping themes included violence against women, poverty, lack of awareness, stigma, and multiple concurrent relationships. A microbicide may be a tool that a woman can use without her partner's knowledge, which could reduce certain situations of violence because she would not have to negotiate for condom use. Many participants acknowledged that negotiating for safe sex can be difficult because it may result in violence from their partners, while sex workers acknowledged that the need for payment often overrides the need for safe sex. The potential for secret HIV prevention options (i.e., only the woman knows that an HIV prevention tool is being used) may reduce or eliminate many of these issues if a woman is able to apply a microbicide without her partner's knowledge.

"It is better to have some form of protection than nothing. Right now we are at the mercy of men, women like myself need microbicides."
~Female participant, Misisi Compound, Zambia

As microbicides continue to develop and move closer to country-specific introductions, it will be important for organizations to conduct research to develop generalizable data that can better outline the core implementation strategy across a majority of countries with recommendations for specific tailoring for the individual countries and communities. GCM found the story-telling technique and the community dialogues to be very effective methods to engage with specific communities, identify future microbicide champions, and develop trusting relationships with local partners and community members to maintain long-term relationships.

"Women and men need to work together in HIV prevention strategies; leaving men out of this discussion is a huge mistake."
~Health care professional, Klerksdorp, South Africa

Furthermore, it is imperative to educate men, as women in these communities often perceive men as the gate keepers to their community and products. The male community parliament participants commented on how learning about microbicides encouraged their desire to use them with their partners. Continued education about HIV prevention options including current safe sex practices and microbicides will help prepare communities for microbicide introduction. Additionally, continued education and awareness campaigns will provide the implementers with end-users' perspectives on points of access and the potential for success or failure in each community, because it will ensure that participants have a baseline for current practices and an awareness of potential best practices for the future.

Moreover, participants identified cost as a specific access limitation. Statistically, the communities in South Africa that represent the highest HIV rates are in the most impoverished categories as well.[12] If microbicides are too expensive, then cost is likely to be a prohibitive factor for women and men in accessing them.

Finally, even though microbicides are in various stages of clinical trials and will be implemented as they become available, it is important to remember that any form of microbicide (e.g., ring, gel, pill, injection) needs to accepted by the community in order to be utilized. Therefore, the community should be educated about the varying forms and the community preferences taken into account.

GCM piloted a number of different models to learn the opinions of potential end-users. Their ideas and experiences provided valuable insight into the potential impact that microbicides

can have in their lives. These models also presented a basic outline for the possible limitations and launching areas for microbicides. Moving forward, GCM recommends that future microbicide implementers continue to engage potential end-users by using the story-telling model in educational and data collection sessions, which will help implementers gain better perspectives on end-users' needs and ideas. Furthermore, these sessions will provide education opportunities for the communities, which participants said was a valuable benefit. GCM predominantly focused on women as potential end-users. In nearly all dialogues, however, women highlighted the value of educating the men in their community about microbicides, which will excite them about these products and encourage their acceptance of women using them. It will be important to maintain communication with both women and men to ensure that all receive accurate information and to develop relationships with specific community members, or microbicide champions, who will help influence the community in utilizing these new tools. The most important lesson that GCM learned from these activities is that more community dialogues and research are needed to develop a specific and generalizable plan for microbicide implementation that includes the opinions and experiences of potential end-users.

Conclusion

Throughout the fiscal year 2011-2012, GCM developed a number of relationships with local partners and potential microbicide end-users in South Africa, Kenya, and Zambia. GCM also was able to learn more about specific experiences from women and men to assist in better understanding the gender imbalances that will be crucial to developing the appropriate strategies for implementing microbicides in these countries. A successful microbicide introduction requires the involvement of a multitude of stakeholders, including members of communities affected by the HIV epidemic. By acknowledging the gender dynamics, sexual practices, access limitations, and best points of entry in communities most affected by the HIV epidemic we can introduce microbicides in ways that will encourage and excite women and men to use these new life-saving products as they become available.

A significant portion of the information gathered during GCM's activities addressed women's experiences with intimate partner violence, their ability to advocate for their own safe sexual practices, their financial dependence on the male members of their community, and women's insights on how microbicides could be included in their lives. Ensuring successful microbicide introduction will require an in-depth study of the identified microbicide entry points to learn the unique aspects of these communities and develop a program that will address the overlapping issues and be tailored for different types of end-users (e.g., sex workers, married women, young girls, etc.). Moreover, it is essential to educate the communities, especially the men, to ensure that everyone has accurate information and is willing to support their female community members in using these products. It is also imperative that the microbicide cost remains low and affordable to the population and that the entire community, including men, women, sex workers, elders, youth, leaders, and the media, are educated and advocating for their use.

While GCM is no longer participating in the microbicide implementation field, there are a number of organizations (both global and in-country) with the background knowledge and ability to reach out to both women and men and begin a study of potential microbicide limitations and successes to ensure that by 2016 (the current estimated year for implementation) South Africa and all countries to follow will have the gold standard for microbicide introduction.

References

[1] Joint United Nations Programme on HIV/AIDS (UNAIDS). *UNAIDS World AIDS Day Report, 2011*. Geneva: UNAIDS; 2011.

[2] UNAIDS. *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV: Operational Plan for the UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV*. Geneva: UNAIDS; 2010.

[3] UNAIDS, United Nations Population Fund (UNFPA), United Nations Development Fund for Women (UNIFEM). *Women and HIV/AIDS: Confronting the Crisis*. Geneva and New York: UNAIDS, UNFPA, UNIFEM; 2004.

[4] Patel V, Kleinman A. Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*. 2003; 81: 609–615.

[5] Friedman E. Gendering the agenda: The impact of the transnational women's rights movement at the UN conferences of the 1990s. *Women's Studies International Forum*. 2003; 26(4):313–331.

[6] Coplan P, Mitchnick M, Rosenberg Z. Regulatory challenges in microbicide development. *Science Magazine.* 2004; 304:1911–1912.

[7] PBS Newshour. Promising Science Highlights from 2010 AIDS Conference. Available at: http://www.pbs.org/newshour/rundown/2010/07/promising-new-science-from-2010-aids-conference.html.

[8] Sokal, D, Karim, Q, Sibeko, S, Yende-Zuma, N, Mansoor, L, Baxter, C, et al. Safety of tenofovir gel, a vaginal microbicide, in South African women: Results of the CAPRISA 004 trial. *Antiviral Therapy*. 2012; In press.

[9] Centre for the AIDS Programme of Research in South Africa - Staff website. Available at: http://www.caprisa.org/SitePages/About-People.aspx.

[10] National Aids Control Council (MAISHA). *Mainstreaming Gender in HIV Responses in Kenya: National Action Plan 2009/10-2012-13*. Nairobi, Kenya: Maisha; 2011.

[11] Kaunda D. Vaginal microbicide trial failed. *New Science Journalism*. January 15, 2010. Available at: http://newsciencejournalism.com/01/2010/vaginal-microbicide-trial-failed/.

[12] National Department of Health of the Republic of South Africa. *The 2010 National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa*. Pretoria, South Africa: National Department of Health; 2011.

[13] Christofides N, Webster N, Jewkes R, et al. *The State of Sexual Assault Services: Findings from a Situational Analysis of Services in South Africa*. South Africa: South African Gender-Based Violence and Health Initiative; 2003.

[14] Peacock D, Levack A. The Men as Partners program in South Africa: Reaching men to end gender-based violence and promote sexual and reproductive health. *International Journal of Men's Health*. 2004; 3(3):173–188.

[15] Project Concern International South Africa website. Available at: http://www.pciglobal.org/africa/south-africa.

[16] MAISHA, National AIDS and STI Control Programme. The Kenya AIDS epidemic updates 2011. Nairobi, Kenya; 2012.

[17] Kenya National Bureau of Statistics (KNBS), ICF Macro. *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro; 2010.

[18] Widyono, M, Ellsberg, M, Michau, L, Prieto, D, Avni, M. *Strengthening Regional Work on Gender-Based Violence* Kampala, Uganda: USAID, Gender-Based Violence Prevention Networks, PATH, Raising Voices, and Interagency Gender Working Group; 2006.

[19] Central Statistical Office (CSO), Ministry of Health (MoH), Tropical Diseases Research Centre (TDRC), University of Zambia, Macro International Inc. *Zambia Demographic and Health Survey 2007*. Calverton, MD: CSO and Macro International Inc; 2007.

[20] USAID. *USAID/Zambia Gender-Based Violence Programming Evaluation*. Lusaka, Zambia: USAID; 2010.

[21] United States Government Zambia Interagency Team. Global Health Initiative Strategy Zambia 2011–2015. Washington, DC; 2012.

[22] Chambers R. Participatory Rural Appraisal (PRA): Analysis of experience. *World Development*. 1994; 22(9):1253–1268.

[23] Beksinka M, Rees H, Kleinschmidt I, McIntyre J. The practice of dry sex among men and women in South Africa: A risk factor for sexually transmitted infections? *Sexually Transmitted Infections*. 1999; 75; 178–180.